MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

NOTICE OF SERVICES PROVIDED & REQUEST FOR DIRECT PAYMENT

W.C. Injury Number
Medical Fee Dispute Number

Use only if services were authorized in advance by the employer/insurer, but payment has not been made, and 90 days or more have lapsed since first billing.

Employee (Patient's) Name	Address *(Street, City & County)*	State	Zip Code	Date of Injury
				Patient's Social Security Number

1. Application is made for direct payment of health care services rendered to the employee in the underlying workers' compensation case. The services rendered were authorized in advance by the employer/insurer, but the medical or health care bill has not been paid.

2. Name of Health Care Provider	Address *(Street, City & County)*	State	Zip Code	Telephone Number
2a. Location of services rendered *(If different than above.)*	Address *(Street, City & County)*	State	Zip Code	Telephone Number
3. Name of Employer	Address *(Street, City & County)*	State	Zip Code	Telephone Number
4. Name of Insurer	Address *(Street, City & County)*	State	Zip Code	Telephone Number

5. **Brief Description of Disputed Services Rendered**	**Date Services Provided**	**Name and Title of Person Giving Authorization**	**Amount Claimed**
A.			$
B.			$
C.			$
D.			$
E.			$
F.			$

(If additional space is required, please attach additional page.)

6. Signature of Health Care Provider	Name/Title/Address of Requesting Party *(Print/type)*	Date
		Telephone Number
7. Health Care Provider's Attorney & Address *(Print/type)*	Attorney's Signature Bar Number:	Date
		Telephone Number

CERTIFICATE:

The undersigned applicant certifies that the foregoing information is true and correct to the best of his/her knowledge, information and belief; and that the said application has attempted to resolve this dispute with the employer/insurer.

The undersigned applicant further certifies that a true and accurate copy of this Notice of Services Provided & Request for Direct Payment, together with a copy of all supporting documentation, as identified herein, have been mailed by first-class mail, postage prepaid, or hand delivered to the above referenced employer, insurer, and employer on this _____ day of _____, 20_____.

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Applicant or Applicant's Attorney